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Sex-Education and Preventative and Contraceptive Services: Educação-Sexual e Serviços Contraceptivos e Preventativos

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**Sex-Education and Preventative
and Contraceptive Services:
*Educação-sexual e Serviços
Contraceptivos e Preventativos***

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Spring 2006**

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INTRODUCTION

Maternal morbidity is one of the leading causes of death amongst women in Latina America. Lack of access to Reproductive Health services has incited a continental epidemic amongst adolescent women - and should be considered a public health crisis. Yet, there is little being done by the governing male bodies to secure access and the Right to Reproductive Health services. This is not only a means of re-enforcing gendered inequalities- but also class, and racial disparities.

Reproductive Health in Brazil and Northeastern Brazil in particular, serves as an allegory for socio-economic, gender, ethnic, and racial inequality in the region. The socio-economic inequality between races in Brazil is an important factor linked to access to Reproductive Health care access. The ethnic and racial make up of the Northeast is key in placing fertility and Reproductive Health of the Northeast in the greater socio-economic and cultural context of Brazil. Over three-quarters of the northeast's population identifies as non-white, compared to just over half of the population of the southeast.

In 1996, 18% of adolescent females from the northeast had been pregnant at least once, compared to the 12% of adolescent females from the southeast. Of these adolescents from the northeast, 51% reported that their pregnancy was unplanned. The percentage of births among adolescents increased from 12% to nearly 19% between 1986 and 1996. Interestingly, during this same period of time, birth rates dropped for women ages 25-39¹. All these numbers indicate that over all, adolescents are not accessing the Reproductive Health services they need, and further, that non-white adolescents from the northeast are at higher risk for unwanted pregnancies.

¹ Neeru Gupta and Iúri da Costa Leite, "Adolescent Fertility Behavior: Trends and Determinates in Northeastern Brazil," Guttmacher Institute, International Family Planning Perspectives, Volume 25, Number 3, September 1999, p. 126.

The Reproductive Health disparity between the Northeast and the South not only illuminates a socio-economic disparity- but also marks a drastic disparity between the Reproductive Health services Black and White women receive. Structural racism is not the only issue Black Brazilians confronts. Simply just addressing the matter as a socio-economic injustice does not reflect the complexity of the issue. A Universal Health Care system is a pre-requisite for dealing with Health disparities- but there have to be specific initiatives that also address the social and personal racism.

For the purposes of this investigation, I will be looking at a public health *planejamento familiar* program, in a rural town just outside of Salvador, where the overwhelming majority of the population is Black. I will specifically try to focus in on how Black adolescent women are accessing Reproductive Health services. What is the public health system doing [or not doing] to provide services for these women? How is the racial inequality being addressed within *planejamento familiar*?

THEORETICAL FRAMEWORK & LITERARY REVIEW

REPRODUCTIVE RIGHTS:

Reproductive Rights recognizes the basic universal Human Right to attain the highest standard of sexual and reproductive health. It implies the right to decide the number, spacing and timing children, to have the information and means to do so, and the right of all to make decisions concerning reproduction free of discrimination, coercion and violence.²

REPRODUCTIVE HEALTH:

The Reproductive Health framework speaks to the necessary Reproductive Health services that women need. Reproductive Health also includes educational and community-outreach initiatives that compliment service. The World Health Organization more concretely defines Reproductive Health services as:

“Reproductive health care is defined as the constellation of methods, techniques, and services that contribute to reproductive health and well-being by preventing and solving reproductive health problems. It also includes sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counseling and care related to reproduction and sexually transmitted infections.”³

REPRODUCTIVE JUSTICE:

Reproductive Justice is the physical, mental, and spiritual well-being of women that necessitates the economic, social, and political power and resources to make healthy decisions about their bodies, sexuality, and reproduction- for themselves.

² *Gender and Reproductive Rights*, Department of Reproductive Health and Research (RHR), [<http://www.who.int/reproductive-health/gender/glossary.html>].

³ *The WHO Definition of Reproductive Health*, Reproductive Health Outlook, [http://www.rho.org/html/definition_.htm].

Reproductive oppression is the result of the inter-sectionality of oppressions and is intrinsically linked to the struggle for social justice and Human Rights. Reproductive Justice promotes a holistic vision, and comprehensive strategies that address the structural and societal conditions that control women by regulating their bodies, sexuality, and reproduction.⁴

RE- THINKING REPRODUCTIVE RIGHTS IN THE CONTEXT LATIN AMERICA:

Moving Away from the Framework of Human Rights

With the abundant amount of literature available about Reproductive Rights as an extension of Human Rights, it is critical that we examine this framework being used- and misused- in order to place the Reproductive Rights movement in Latin America in a global context.

Over the past few decades internationalist organizations like the United Nations have focused on the concept of Universal Human Rights as the framework for international social justice. Accordingly, the rhetoric of Human Rights has also been adopted by groups with internationalist ambitions- namely the U.S. government (the Clinton and Carter administration in particular). The discourse of Human Rights was adopted to promote U.S. international, political, and economic interests. The early 1990's saw a surge in Human Rights initiatives on behalf of the U.S. Government. As the U.S. government became more and more involved in the Human Right trend, critics of the U.S. government reconsidered the polemical and practical issues surrounding Human Right: Who is defining, defending, and financing Human Rights?

Particularly with regards to Reproductive Health in Latin America, Human Rights advocates have completely slanted the accomplishments of the Reproductive Rights movement in Cuba, which has moved mountains in comparison with other

⁴ Eveline Shen, *Reproductive Justice*, The Center for American Progress, January 2006. As cited in: [http://www.motherjones.com/commentary/columns/2006/01/reproductive_justice.html].

Reproductive Health movements in Latin American, and the movement in the United States. Cuba is:

- the only Latin American that has comprehensive Universal Health care;
- the only country in Latin America where abortion legal;
- and moreover, along with Canada, is one of the only two countries in Western-hemisphere that provides government subsidized abortions.

Yet, despite these triumphs, Human Right advocates have condemned Cuba as a violator of Human Rights:

The Cuban government systematically denies its citizens basic rights to free expression, association, assembly, movement, and a fair trial. It restricts nearly all avenues of political dissent, and uses police warnings, surveillance, short term-detentions, house arrests, travel restrictions, criminal prosecutions, and politically-motivated dismissals from employment as methods of enforcing political conformity⁵.

What *basic rights* are they referring to? How are they qualifying Human Rights?

Understanding the subsequent implications of Human Rights, and the socio-political circumstances that surround Latin America at this juncture, specifically with regards to the issue of reproductive health, we will use the concept of popular democracy as the esoteric basis for this theoretical framework

Sexual and Reproductive Right as an integral part of Popular Democracy:

O que significa tratar sexualidade e reprodução como dimensões da cidadania e consequência, a vida democrática. (What is the significance of treating sexuality and reproduction as a dimension of citizenship and consequently, democracy?)

With a new wave of democratically elected left-of-center governments rising to power in Latin America, it is critical we understand Reproductive Rights within the context of these democratic processes. In this moment of social transition, leftist moments in Latin America are calling into question the idea of rights, freedom, and democracy. They are moving away from the bourgeois vision of individual liberties and rights, and re-defining popular democracy. It is vital that Reproductive Rights advocates insert

⁵ Cuba: Human Rights Concerns for the 61st Session of the U.N. Commission on Human Rights, Human Rights Watch, [<http://hrw.org/english/docs/2005/03/10/cuba10306.htm>], 2005.

themselves in these movements- and make the critical connection between Reproductive Rights, Health, and Justice, and creating a more democratic society.

In the past, Reproductive Rights were solely projected as a feminist issue. More recently, advocacy groups have taken on the issue of Reproductive Health and Justice, understanding a women's sexual and reproductive health as an integral part of sustainable/ community development, environmental preservation, socio-economic equity, etc. Activists and advocacy groups are beginning to locate Reproductive Health, Rights, and Justice within the broader social justice framework that seeks to bring an end to poverty and discrimination, and affirm self-determination.

The feminist movement initially understood the question of Reproductive Rights as an issue of Sexual Rights; that is, sexual equality. As an extension of this discourse of equality, Reproductive Rights can be understood within the concept of *cidadania* (citizenship), and *a vida democrática* (democracy):⁶ “Uma política pública de saúde comprometida com a promoção integral dos direitos reprodutivos e sexuais representará uma conquista política para democracia⁷ .” Reproductive Rights are a prerequisites to a woman's political enfranchisement, and are central to the democratic process .

Reproductive oppression is not solely a corporal concept. Historically, women have had limited access to the institutions responsible for creating and implementing policies that directly affect their lives. Women's bodies have been the political arena where gendered social exclusion has been enacted. In the case of Brazil, as is the case with the rest of Latin America, the bodies of colonized women were and still are the grounds of colonization [sexual exploitation]. Their sexual and reproductive lives have been dominated by men in power. As the governing body in Brazil is still White, and male, this same colonial pattern is indefinitely being acted out in the political realm. Recognizing this history of domination, the discourse of Reproductive Rights Health and Justice amongst women of color, and colonized women is calling attention to the

⁶ Maria Betania Avila, *Direitos sexuais e reprodutivos: desafios para as políticas de saúde*, Cad. Saúde Pública, Rio de Janeiro, Agosto 2003.

⁷ Ibid, pp. 4.

intrinsic contradictions of these bourgeois democracies that function as extension of colonial and patriarchal structures. So long as these infrastructures continue to dictate the reproductive lives of women, political-national autonomy will remain an empty concept, real social transformation will never be realized.

The discourse of Reproductive Rights speaks to an ideological and practical woman's liberation. A woman's capacity to break away from her biologically prescribed gender role is a precursor to real social transformation, and participative democracy. How she is interpellated into her community, society, the work force, and the world market is predicated on her biology; in order to escape from this normative, a woman must be in control of her own reproductive life. This framework is also calling into question the history and privilege of the governing bodies: Who has made up these governing bodies [and controlling women's bodies]? As a starting point for more equitable governing, policies, and democracy, Reproductive Rights must be weighed-in, and power dynamics within the governing bodies must be considered.

It is not enough to loosely verbalize a vague commitment to sexual equity. Reproductive Rights must move further into the foreground of social movements, as a means of dismantling biologically gendered roles, and providing the basis for social transformation and the democratic process. Thus far, certain women have been the sole beneficiaries of the Women's Liberation Movements. Until Reproductive Health services are universally accessible, and policies have been enacted that attend to the non-structural inequalities, public health policies will only perpetuate the disparity between wealthy/poor, Black/White women.

THE CONTEXT OF THE NORTHEAST

ACCESS TO REPRODUCTIVE HEALTH CARE

As a whole, Brazil has experienced a drastic decline in fertility in the past few decades: from 1970- 1996 the total fertility rate (TFR) dropped from 5.8 lifetime births per women, to 2.5. While these statistics definitely demonstrate a positive trend in Reproductive Health Care access, it is also important to note who is accessing these services. The decline mostly reflected a decrease in TFR in middle-aged women. Conversely, the fertility rate of adolescent woman has been rising. Between 1986 and 1996, the percentage of adolescent women giving birth rose from 12% to 19%. Specifically in the Northeast, teenage mothers represented 20% of all births in 1996, as compared to the 12% they represented 10 years earlier. The instances of adolescent single-mother-births also increased over the same 10 year period from 5% to 11%. (Though is also important to note that the number adolescent women using contraceptives rose from 55% to 72% in that same ten year period.)⁸ These numbers are particularly significant because of the other issues that surround teenage pregnancy and parenthood: higher maternal morbidity and infant mortality rate, more instances of clandestine abortions, higher risk of birth complications and low-birth-weight babies, in addition to the other practical problems young mothers must confront (mothers have to leave school and are integrated into the worked with few skills, and lower level of education, etc). The increasing fertility of adolescent women, specifically in the Northeast indicates a public health crisis. This is particularly jarring since younger women generally display lower natural fertility rates (in terms of a woman's reproductive life cycle). This implies that older women are able to make better use of

⁸ Neeru Gupta and Iúri da Costa Leite, *Adolescent Fertility Behavior: Trends and Determinates in Northeastern Brazil*, Guttmacher Institute, International Family Planning Perspectives, Volume 25, Number 3, September 1999, p. 126.

family planning services. The ethnic and racial make up of the Northeast in particular is also significant factor in placing fertility and reproductive health of the Northeast in the greater socio-economic and cultural context of Brazil.

The racialized socio-economic inequality in Brazil is a significant factor linked to Reproductive Health care access. With 45.5 million inhabitants, the population of the Northeast represents 29% of Brazil's population, and 46% of all rural residence. Over three-quarters of the Northeast's population identifies as non-white, as opposed to just over half of the population of the Southeast. The racial and socio-economic make-up of the region marks a drastic disparity between Reproductive Health access between the South, and Northeast.

The region represents some of the countries lowest socio-economic indicators. The infant mortality rate is almost twice the national rate (74 infant deaths per 1,000 live births, as compared to 39 per 1,000 nationally). In 1996, 20% of adolescent females from the Northeast had been pregnant at least once, compared to the 12% of adolescent females from the southeast. Of these adolescents from the Northeast, 51% reported that their pregnancy was unplanned⁹. Level of education of is one of the most important socio-economic indicators in terms of analyzing fertility, and is intimately related with infant mortality rate. Education is considered is a key factor in transforming fertility rates. Accordingly, the levels of education in the Northeast are significantly lower than in the South.

Additionally, the Northeast represents a large majority of Brazil's rural population. In general, fertilities rates are expected to be much higher in rural areas as compared to urban centers- which is holds true in the Northeast. The TRF for urban areas is 2.3, as compared to rural areas, where the average number of live births is 3.5. It is also important to take into consideration the rapidly growing population of the urban centers; many rural dwellers are piling into urban centers. This has also significantly influenced the decline in fertility overall.

⁹ Ibid.

METHODOLOGY

Using the town of *Maragogipe* as my main case study, I gathered anecdotal evidence about Reproductive Health care, specifically servicing Black rural adolescent women. As much as I could, I tried to embed myself in the public health center. My general observations took a three prong approach. First, I tried to familiarize myself with the services available and the protocol for the [ethical] delivery of these services. Second, I tried to understand how public health workers are administering these services, and finally, how Public Health Center were addressing, or were not addressing the needs of the community.

On an administrative level, I wanted to see how public health was strategically addressing *planejamento familiar*. To get a better understanding of the infrastructure within the municipal health system, I spoke to several public health officials, and conducted a formal interview with the public health director. I also spoke to public health professionals, doctors and nurses. I specifically wanted to see how public health policies are being enacted on a personal level. I also wanted to hear their critics of the policies.

Last, but most importantly, I spoke to several informal public health workers (*técnicas*, and *promotoras*). These individuals were my most important informants, and the focal points of my investigation. As community members themselves, they were able to acutely gage the effectiveness of these services, define the short-comings of the Public Health, and were able to make truthful recommendations as to ethical delivery of Reproductive Health services.

OBSERVATIONS

MARAGOGIPE: A PUBLIC HEALTH CONUNDRUM

Maragogipe is a small town about 3 hours outside of Salvador. The town has about 43,000 residents. There are 6 districts that make up Maragogipe; the districts are spaced out several kilometers from each other. The main district of Maragogipe serve as the community center; most businesses and offices are located in the central district. The upper schools are also located in the main district of Maragogipe. The local economy of Maragogipe is drastically different than the districts; as Maragogipe is the business center, the economy is supplemented by trade. This is not true of the districts: there are few, if any businesses. Most of district residents earn their livelihood from agriculture, or fishing. Accordingly, there is a substantial difference in the quality of life.

There has been an effort on behalf of public health officials to disperse public health service amongst the districts. The town hospital and secondary services are located in the main district of Maragogipe- but there are *postos de saúde* in all the districts that are suppose to administer primary care to the districts, and the surrounding area. However, with the lack of overall resources, it is difficult enough to provide basic services in the district of Maragogipe- let alone throughout the other districts.

Each district has a *posto de saúde*, which offers primary care services; individual posts are intended to serve 4,000 community members. Health care workers all agree that the posts serve more than the intended 4,000 patient, and that even if they only served 4,000, they would not have the resources to meet the needs of the community. On paper, each post has their own director, and a fixed primary care staff that includes a

nurse, several *técnicas*¹⁰, individuals who specifically administer vaccines, a receptionist, a dentist, and a community-based peer counseling team.

Most of my research was collected at Nagé, a district right outside of the Maragogipe. At that particular *posto de saúde*, there was no doctor. The doctor who was stationed at that post left for interpersonal issues [and a lack of commitment to the community]. The *posto de saúde* was functioning with one nurse, a couple of peer counselors, and a dentist. As services were limited, peer counselors implored the community to help them promote preventative medicine- that is, promote healthy living to prevent sickness. Of course, preventative medicine is difficult to employ when the basics are even limited. It is a model that was pioneered by the Cubans; public health is the center-piece of their public policies, and is one of the largest government expenditures. Nagé clearly does not have the capacity to replicate that model on a local or community level. Though the preventative medicine model is suppose to reduce Public Health costs (and demand), it requires basic services and resources that Nagé cannot offer.

REPRODUCTIVE HEALTH AND *PLANEJAMENTO FAMILIAR*¹¹

In Brazil, the most commonly used contraceptive method for middle-aged women was female sterilization (41%), and then the pill (19%). Among younger women, the pill is the most prevalent of contraceptive (27%) follow by the condom (10%). In the Northeast, the trend was similar, though usage rates were much lower (18% for the pill, and 8% of the condom). However, the more than two-thirds of adolescents using contraceptive relied on services from the private sector¹².

¹⁰ *Técnicas* have some formal training to perform certain tasks- have limited credentials. They have proven to be critical in promoting Reproductive and Sexual Health in South Africa and Haiti, particularly in the battle against HIV, and AIDS treatment.

¹¹ *Planejamento Familiar* in Brazil only refers to contraceptive and HIV and STD prevention. All the other Reproductive Health services: Breast and Cervical Cancer Screening, Prenatal care, Delivery Services, etc., are not included Reproductive in Health- and generally not offered at Public Health Facilities.

¹² Gupta.

Specifically in regards to Reproductive Health services, there are no federal guidelines that speak to the delivery of Reproductive Health services. Most of the Posts did not have specific programs designed to address Reproductive Health needs. At most, there were a few individuals on staff who are more familiar with Reproductive Health issues, and sometimes called upon to give informal workshops of contraceptive methods, and AIDS prevention. Generally, these individuals are generally more experienced health care workers who either individually sought after more information, or had life-time experience on reference.

If any of the public health centers offered more comprehensive services (beyond the actual distribution of contraceptives) they generally are receiving some form of aid of a national non-governmental organization called BEMFAM. BEMFAM provides funding, contraceptives, and training for healthcare workers (professional and non-professional). BEMFAM attempts to fill in the blanks where the public health system fails. They produce general guides on program organization, materials for distribution, and general healthcare guidelines. These are generally the only the reference public health workers have at their disposal. They offer *capacitações* for the general public- and specifically young people about preventative and contraceptive services, the discourse of Reproductive Rights, and general topics that are interwoven with sexual and reproductive health.

BEMFAM is the primary reference point for public health centers in Maragogipe. Most of the information they distribute to the public has been funded and produced by BEMFAM. The peer-counselors have been either been trained by BEMFAM, or have received training from a public health worker who has been trained by BEMFAM. BEMFAM is not a federal program (although it receives financial support from the government); it works in conjunction with the local *prefeituras*, with teams of peer-counselors.

The peer counselors decimate health information. Community-outreach has proved to be key in reducing unwanted pregnancies, fighting the spread of HIV, and

getting basic information out to the communities. These groups have been key informants in and for the community; because the public health system is drastically under-staffed, these peer-counselors very often take on the role of health professional, and play an integral role in the public health system. A lot of the ailments that plague the community are from a lack of education, and basic health information. The peer-counselors really are the back-bone of community health. Lack of funding, personnel, training, and resources has made it difficult for Public Health officials to develop and maintain these kinds of alternative programs.

WHY ARE ADOLESCENT WOMEN NOT ACCESSING SERVICES?

The main question I tried to address through my informal interviews was why young Black women are not accessing services. With little time in the periphery, it becomes crystal key why these women are not accessing Reproductive Health services.

Though public health officials have been trying to promote the services they have available, they lack the funding to provide adequate, and comprehensive services. They do not have the time, ability, or personnel to push community-outreach, and other educational initiatives. This shortcoming was not in anyway a reflection of the commitment of the health officials themselves. In my research, I encountered the most dedicated doctors, nurses, and *técnicas* that were passionate professionals- and more than anyone else, fully aware of the short comings of the public health system. The public health profession demands an enormous amount of commitment; you work in conditions where supplies and assistance is limited, to say the least. It is not an overstatement to say these were some of the most competent and serious professionals I have ever encountered.

There are signs that the wheels are in motion, and that reproductive health is moving up on the Public Health program but the conservative attitude of community members continues to serve as impediment Reproductive Health. One of the nurses who gave talks to community about contraceptive methods, Nurse Chanelle, claimed that the

culture was holding back the few initiatives that were able to get off the ground. She went onto describe her experience at a local school. She recounted that some of the students were too immature to even begin to engage the issue- and so it was difficult to talk other students, who were ready to have serious conversation about sexuality, and their sexual health. She also went onto to say that it was equally critical to hold workshops for the parents. Though it is important to reach-out to young people, and inform them of their options, their primary social agents were their parents. You need to establish a base at home that would re-enforce sexual and reproductive health. She has had several experiences, where some of the students she spoke with have gone home, and been reprimanded by their parents for seeking information about sexual health. It is imperative that they also take on the task of transforming society as a whole, so that young people could have open and honest conversations about sex.

BEYOND THE STRUCTURAL RACISM

The structural racism is easy to localize within the public health, and specifically in the case of Nagé. The majority of the women that were being serviced at that specific *posto de saúde* were Black. Accordingly, the post was incredibly understaffed, lacked options within *planejamento familiar* (there was no variety in contraceptives), and in general, lacked the resources to provide comprehensive, and adequate services. However, speaking with health professionals, you begin to understand that the issue of racism within the public health system transcends the availability of resources- and cannot be solely explained as an issue of access.

One of my most important informants, nurse Nara, described her experience as a professional within the public health system, and how on a professional level, she encountered racism. Initially, when she came to state of Bahia, she applied for a job at several hospitals in Salvador. She assumed with her years of experience, and references in Sao Paulo, she would not have much difficulty finding a job. Yet, time and time again, she was rejected at every hospital. As was protocol, she had to take a written exam in

order to qualify. She always passed, and at that, passed above and beyond the requirements. However, there was always a second component to the process. She had to do a group interview with other candidates to see how they would interact, and how they would socialize. Allegedly, this is where she fell short. Despite her years of experience, she was not competent for the job- nor were the other Black applicants. In general, the people hired for the job were White, some with less experience than herself. She was not as qualified to administer services in Salvador- a city where the majority of the population is Black.

Though Nara's experience was within Human Resources was just that, her experience, other professionals I spoke with recounted similar experiences. Institutional and interpersonal exclusion was a norm for Black professional entering at all levels of the public health system. Though it points to a problem within the administrative processes, it provides anecdotal evidence of a larger problem that transcends the structural racism. It is not a grand leap to make the assumption that these politics influence the quality of services Black women receive. In an informal survey Nara conducted, she found that on average, White patients are asked 7 questions when they spoke with health professionals for a consultation. Black patients are only asked 3. The time doctor spends with Black patients, which on a practical level, is indicative of the quality of services, and is drastically less.

On a very personal and elemental level, Black women are not getting the same services White women are accessing. While universal healthcare reform is a precursor to confronting the service disparities between Black and White women, the aforementioned anecdotal information suggests that there are limitations as to how deep structural protocol can penetrate. There have to be supplemental, cultural and community initiatives that confront these issues they lay beyond the systemic surface.

CONCLUSIONS

There is as huge disconnect between the theory and practice. The theory of Reproductive Health, Rights, and Justice has very little to do with the actual services being administered at Nagé, and Maragogipe. Not for a lack of trying- but for a lack of everything else: personnel, resources, funding, education, etc. The overlap between Reproductive Health and the discourse of race is even harder to introduce. When peer-counselors conduct *palestras* and *capacitações*, they try to talk about the idea of rights, citizenship, the democratic process, and racism. As much as they can, they try to raise awareness of the social factors that prevent these women from accessing quality services. But how much of it is absorbed, in the tiny lounge of the *posto de saúde*, with a room full of infants crying, and women anxious to get back to their domestic responsibilities, is questionable.

While there is a real effort by dedicated individuals to provide ample, comprehensive services, and to engage the discourse of race, rights, and democracy, resources are limited. When there are hardly the material requirements to provide the basic services, theory takes the back-burner.

POLICY RECOMMENDATIONS

There is very little government support for family planning, which is indicative of the overall infrastructure of the municipal, and public health system. The few *planjamento familiar* programs that exist have been spear-headed by individual public

health directors, and individual providers. There are no guidelines as to the organization of services, much less, the ethical delivery of these services. Accordingly, there are very few resources available for public health centers. The only initiative that has provided a practical framework for administering services is BEMFAM. As a whole, the public health needs to be prioritized within public policy. That is, there needs to be more government spending on public health.

The public health professionals I spoke with also stressed the importance of decentralizing services. Especially in the periphery, services need to be made available locally. It is difficult for many rural dwellers to access basic services- simply because of the lack of transportation.

On a practical level, decentralization speaks to the issue of access; however, it also reflects varying needs of particular communities. For example, *Quilombo* communities have very specific needs that are not necessarily prioritized on a federal level, but are very pertinent to that community. While it is vital that the governments create national policies that prioritize *planejamento familiar*, the execution of these policies should be determined by the communities- the programs themselves should be run autonomously from the government, and be community-based.

Though formal health care providers play a pivotal role in educating the population and decimating services, young women's level of education is the single most important factor consistently associated with probability of giving birth during adolescence. Adolescents without a secondary school education are twice as likely to give birth as adolescents with secondary school education. Thus, a round-about way of dealing with the Reproductive Health crisis is by improving the education system a whole. All these issues are very much interconnected, and serve as important resources for young women to access Reproductive Health information. Other community-based institutions and organizations (community centers, sports centers, and NGOS) should incorporate Reproductive Health initiatives into their programs as integral components

of community development. These types of informal providers and out-reach are strategically key to more widely providing services.

The question of addressing the racial disparity within Reproductive Healthcare is complicated- and aggravated by all the other impediments public health providers. However, it is possible to create policies that take into account the complexity of the issue, and begin to chip away at the extra-structural factors.

There needs to be special committees that work within the public health system, organizing *capacitações* and *palestra* for public health professionals, to understand what is meant by the ethical delivery of services, receive diversity training, and understand how racism persists below the surface. Additionally, they should receive training that specifically deals with the physical and mental health ailments that particularly afflict the Black population. There also need to be specific initiatives and funds that target *Quilombo* communities. Though as a whole, rural areas are entirely neglected by public health, *Quilombo* communities face the brunt of this neglect. Understanding the history of these communities, health professionals have to incorporate a cultural and historical perspective into the delivery of their services. Accordingly public health institutions have to have policies that ensure that Black professionals will not be excluded. Local institutions and health care provider should organize committees that revise community health and *planjemento familiar* programs, and create policy recommendations that attend to the needs of Black community members.

Nonetheless, all the policy recommendations in the world could not begin to address racial and social inequality without a comprehensive universal health care program to lay-down the groundwork for dealing with the resonating social issues. **Above all, there needs to be a radical change in what people assume as a *basic right***; so long as reformism and pragmatism continues to shape the politics of Brazil, women will be denied the right to Reproductive Health care; and Black women will disproportionately be affected by gendered policies, politics, and power dynamics

APPENDIX

I CONDUCTED FOUR INFORMAL INTERVIEWS WITH HEALTH CARE WORKERS, AND PUBLIC HEALTH PROFESSIONAL IN MARAGOGIPE AND NAGÉ. THEY HAVE ALL BEEN LOOSELY TRANSCRIBED AND SUMMERIZED IN ENGLISH.

One of my most informative interviews was with Nurse Chanelle. She had recently moved to Maragogipe from Minhais Gerais. She has specifically worked on the issue of Reproductive Health, and contraceptive distribution in Minhais. Part of the reason she came to the periphery was to continue to work on Reproductive Health- understanding the difficulty women from the periphery encounter accessing services. Her interview was especially key in contextualizing Reproductive Health services in the Northeast, and specifically, in the periphery, in the greater spectrum of Brazil. As she was also becoming familiar with the Maragogipe, her she still had a fresh perspective, and was able to offer up an external critique of the situation in the periphery.

Q: What kind of sexual-education programs or initiative do you have here?

A: I have actually only been here a couple of weeks, so I am still learning and becoming acquainted with the facility. Here at the [health] center I know we have talks about services that are available and sexual health. A lot people don't know what kind of services are available, and do not talk about these issues at home, so we get people of all age groups coming in with questions, and advice.

Q: Do you go out to the local schools to talk to young people?

A: Yes. We sometimes go to schools to give talks about the changes that people are going through, and prevention, and contraceptives. We have also started to train teachers so they are prepared to talk to the kids also. They are important resources for the kids. There is only so much we can do- and we can only be there for a day. We have trainings for the teachers so that they are able to give the kids correct information about services, and how to get them.

Q: What is the age group of the kids you talk to?

A: We started off with teenagers, it was clear that we needed to start with younger kids, because a lot of them were starting to have sexual lives as young as 12, so it was clear to us that we needed to start at a younger age.

Q: What kind of contraceptives do you offer at this Health Center?

A: We have oral contraceptives, injectable contraceptives that are administered every three months, and the condom.

Q: What is the most popular?

A: The condom and the pill are the most popular, although a lot of women opt for the injection so that their husband, boyfriends, and/or parents don't find out.

Q: How much do they cost?

A: All the services that are offered here are free. It would be even harder to get people to use protection and contraceptives if we didn't give it away.

Q: I've spoken to a lot of women here, particularly young women, who say they stop taking the pill because the pills that the Public Health system provides have high levels of estrogen, and a lot of women experience difficult side-effects.

A: Girls just use that as another excuse not to use the medication. After three months, their bodies get used to the chemicals, and they don't experience the side-effects anymore. The problem is that they also go on and off the medication according to when they are sexually active; if they consistently stayed on the pill, then they would not experience the side-effects every couple of months.

Q: What has been your experience here so far, compared with where you came from?

A: In general, I think that the periphery is much more culturally closed off than the city. It is not only that they don't have access to services, but that culturally; people are more closed off to conversation. Young people are not talking about sex, and their parents are not letting them have access to information. I give a talk about sex education. Not only about contraceptives, but just about basic questions people have about sexuality, about the changes in their body, etc. As soon I started having these talks, I realized there was a need to talk to the parents of the kids. Even though it was important to talk to the kids, it was equally important to talk to their parents. Even if we could teach them about contraceptives, and about their sexuality, when they went home, they would talk to their parents, and they would completely negate what we would say. The parents would ask them what they learned in our talk, and then tell them otherwise. The periphery is really closed off. In order to make people aware about their options and about the services available to them, you also have to address the community and the society that is telling them otherwise.

The most important actors with the Public Health system are unquestionably the peer counselors. Because the Health Centers are drastically understaffed, these individuals have been critical in disseminating information. In theory, Health Centers in the periphery try to promote preventative medicine. However, as they are largely understaffed, and do not have the facilities or the resources to provide for their patients, they only practice preventative medicine on paper. My most informative interview was with one of the peer counselors named Januario de Silva Brandou. He had always lived in Nagé, and was one of the older auxiliaries. He had undergone and three month training in Maragogipe to become a peer counselor.

Q: Can you tell me a little bit about what your function is, and how you promote planejamento familiar.

A: My official title is *auxiliar de saúde*. My job is to serve as an intermediary between the PSF in Nagé (Posto de Saúde Familiar). The community peer counselor informs the community about general preventative services, and checks in on the families to make sure they are doing alright. We keep an ongoing record of the pregnant women, and of people with specific disease (diabetes, etc.).

The houses in the community are divided amongst all the peer counselors. Each peer counselor is responsible for all of the family members in the house. We are supposed to make regular visits to the house. We keep a record of certain members, and have to fill out a federal survey. The survey does a family history, asks for general health status, and sexual activity, etc. We try to make sure that young people are getting the services they need, when they need. A lot of times, they don't know what they have available to them- or how to protect themselves. So we try to make ourselves available as a resource. For every survey we fill out- the municipal gets about 40 *reals*. We don't see any of that though. It's funny because everyone tells that we are important, and that the public health system would not be able to function without us, but we are not compensated for what we do. We are all community members. The work we do is important for the community, and everyone recognizes that, but we are not paid for the work we do. This *prefeitura* has really helped a lot- but it is not really up to him.

What we really try to do is just get information out there. A lot of people doing even know the basics- and there is a lot of information out there that is just not true. One of the recent issues is with younger mothers who don't want to breast feed. They think that if they breast feed- their breast will fall, become saggy, and they will never be able to get another man. It is so important that they breast feed in the first couple of months. Regular milk does not have the nutritional content, or the anti-bodies that breast milk has. Their babies suffer malnutrition, and are even more susceptible to sickness. It is unimaginable that they would not feed their child to maintain their figure- but these are young girls who don't have access to information. It is also a cultural issue. Women here don't understand that being a mother is a responsibility. They don't understand

what being a mother demands- so they don't use protection, and when they do have kids, they don't know to care for their child. And their mothers only reinforce these things. A lot of these girls are having children at 14, 15 – just as their mothers did. A lot of these girls are getting married at 14 because their mothers don't want to have to take care of them anymore, so they arrange a marriage for them. It is not just that these girls don't know any better, and that the Health Centers trying to reach, it is that society altogether is telling them to find someone, have child, etc.

Q: Do you distribute contraceptives?

When I go to the houses, I ask the girls about their sex lives, and I try to talk to the younger ones before they start having sex, so that way, when they start having sex, they can go to the post and participate in a workshop. If the women want contraceptives, they must attend a talk about prevention. We basically try to tell them how to use contraceptive, how they work, and why it is so important. Most of these women don't even know how their own body works, so as much as we can, we try to teach them how it is that the female and male body works.

Fala sobre métodos contraceptivos e preventativos:

About once a week, Nurse Nara, and the peer counselors organize a talk about sex education and prevention. In order to get start a round of contraceptives, they must attend this talk. They cannot receive contraceptives (the pill or the condom) without attending this meeting. (The answers have been paraphrased)

Q: Qual é melhor?

A: There is no better method. Every individual is different. It depends on what works best for your life style, and your body. However the condom and the female condom are the only methods that are able to prevent STD.

Q: A pílola faz mal?

A: Again, this depends on your body. Some women take longer to get accustomed to the chemical combination. Some women take several days, weeks, months, etc. It depends on the individual.

Q: Quando se incia?

A: In general, you begin oral contraceptives on the first day of your period, although different brands of pill have different requirements. It is always best to ask a nurse or doctor about how to take the pill, and when to start. It is always better to take the pill in the morning, that way if you forget, you can still have time to take it in the evening.

Q: A partir de que dia comença?

A: The day you begin the pill, is the day it starts to take effect.

Q: Na pausa de sete dias entre uma cartilia pode ter relações sim engravidar?

A: You will not get pregnant in the 7 days that you do not take the pill. This is the part of your cycle in which your body cannot get pregnant. However, if you are irregular with your pills, they will not be able to regulate your cycle.

Q: E se eu esquecer de tomar um dia?

A: If you forget to take it one day, you should take two the following day. If you can, take it as soon as possible, by don't change the time you take your pill.

Q: Devo parar a pilola para organismo descansar?

A: No. This medication has been provided you to health professions- and is meant for you to take continuously. You never have to worry if medication has been given to you by health professionals, and they tell you take it.

Q: Quero se adiantar minha menstruação. Posso continuar tomar a pilola sim parar?

A: No. You should never take the pill continuously. It is meant to regulate your cycle. You should never try to change your body's cycle, unless a nurse or doctor tells you to change you pattern.

Q: E verdade que a pilola faz engordar?

A: No. The pill has different effects on each person. Some people gain weight, some people get nauseous, some people get headaches. The effects are different for every individual. *Cada organismo é diferente.*

Q: E se eu não faço ter relações por um grande tempo?

A: You should still continue to take the pill. Since it does take a while for your body to get used to the pill, it is better that you consistently take the pill, so that your body isn't constantly having to get used to a new chemical. In addition, you never know when you might have relations. Sometimes, these things are unplanned. It is better to be safe, and continue taking the pill so that when you do meet someone, you are prepared, and don't have to wait for your next cycle. It is also better because you will already be used to taking it everyday, won't forget as easily.

I conducted an ongoing interview with Nara, the only nurse at the posto de saúde in Nagé. She is originally from São Paulo. She did her schooling there, and worked for several years at a hospital in the city. Because of other extenuating circumstances in her life, she found her way to Salvador. Initially, she tried to get a job in the city, but, as she explains in the interview, it is very hard for Black women, even a trained nurse, to get a job in Salvador. She lived in Salvador for a year, before moving to Maragogipe, where she currently resides. She has been at Nagé for about a year. She is the only nurse at the posto de saúde in Nagé. There is currently no doctor.

Q: Can you tell me a little bit about how you got here, when did you start, etc.

A: I am originally from São Paulo. I worked as a nurse there, but because of some personal issues I was having, I decided to go to a place that was not as *agitada*. One of the doctors I was working with said that I should leave the city, and try to find a place a little more *tranquilla*. So I came to Salvador thinking that it was going to be more relaxing, and open. I think a lot of people have that image of Salvador; the reality is far from that. It is very racist- much more racist than São Paulo. In São Paulo, I could get a job easily. I never experienced what I experience in Salvador in São Paulo. I applied for

a job at two hospitals in Salvador, and neither of them called me back. First, you have to take a test just to show that you are competent. It is standard protocol where ever you work. I passed the test easily. Then, you are asked to participate in a group interview. I thought they went well, but both times, I was not called back. And neither were the other Black candidates. After a year, of living in Salvador, and looking for a job, Dr. Andreia told me to come out here. They always need people, and it would be good to get away from Salvador. Andreia always brings everyone with her. That was about a year ago, now, I have been here for almost a year.

(Nara and I spoke for an extended period of time. A lot of the information she shared with me was not prompted by any particular question, but supplemented other discussions, and added some texture to her other responses.)

- It is really difficult here, in the rural area, because people really don't know what is available- but they also don't want to help themselves. There is this one woman, who lives in the rural area. She is 29 and has 11 kids. I keep telling her you need to take your pills or else you are going to have another kid that you cannot provide for. And she keeps coming with another kid. Its not that she doesn't know, because we have all when trying to reach out to her.
- It is also a societal issue. Girls see their mothers, young, raising kids, and they continue in their mother's example. The mothers don't want to talk about sex, or worse, want them to get married so they no longer have to be responsible for them. There was one girl who was already married with a kid at 14, because her mother had so many other kids to worry about, that she just wanted her out of the house.

*Q: Can you tell me about the family planning program that you guys have here? You should probably talk to one of the peer-counselors, but basically, we train a team of community members to serve as health counselors. Because we don't have that many resources it, is important that we maintain contact with the community. They are trained in general health and well being, but they also organize specific *palestras* about *planjamento familiar*. Most of the time, we only have condoms, and the pill. We*

sometimes have injections, but they run out fast. We distribute those based on who has been keeping up with their birth control. People that have proven to be consistent, and have been coming in month after month to get their pills, will be prioritized over people who are not as responsible about their birth control.

Initially, in order to get birth control, women have to come in, and sit through a *palestra*. After the *palestra*, I individually sit with each attendee, and make sure they understand how to take the pill, and use the condom. No matter how many times you tell them, no how many different ways you say it, there are always people who forget, or weren't paying attention, or just don't understand. But, you have to be patient, and just keep re-enforcing it. The women only have to sit through the *palestra* once- if they consistently take their pills. Then, they come in every month, to get a refill. If they keep up every month, they don't have to come in again. But, if they are late, or miss a month, etc, they have to sit through another talk. We do this for a couple for a couple of reasons. We want to make sure to maintain contact with the women, so we have them come in to get their pills every month, and check in with us. Make sure everything is normal, and really try to promote preventative medicine. It is also to make sure that they are correctly taking their pill.

As an extra incentive to be consistent, we have them come and sit through another talk if they skip a month. We know it's hard for some women to find time to sit through another *palestra*, but hopefully, if they are taking their pills, they won't need to. As another incentive, we only offer injections to women who are consistent with their pills.

Q: Those two girls that came in here asking for birth control- you said that they had to come in with an adult or their guardian in order to get medication. What is your age policy here?

This is a general policy that the municipal has. If a minor comes in, a kid under the age of 18, we are legally, unable to give them any medication. If they want birth control, they are going to have to bring an older member of their family to claim responsibility

for them. We cannot be held liable for giving them a medication that their family is not away of. If anything should happen, we do not want to be held responsible.

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